ADULT SUPPORT & PROTECTION

Background
Ms A was aged 87 when she died. She was known to services prior to her death and had previously been assessed as an 'Adult at Risk'. She was diagnosed with mid-stage early, onset Dementia & was known to be frail and prone to falls, requiring mobility aids. However in the weeks leading to her death there was a rapid deterioration in her mobility and her husband showed signs of being unable to safely assist her with concerns about domestic abuse/potential physical harm identified.

Domestic Abuse & Coercive Control
There was a recognition of concern that Ms A was at risk of physical harm by her husband. However the identification of this was delayed. Ms A's husband spoke on her behalf and she was never spoken to on her own - her voice was not heard. He displayed verbally & physically aggressive behaviour towards Ms A and the incidents were categorised as her husband suffering from Caregiver Stress Syndrome.

What does this mean for you as a practitioner, your team and your service?
Bring this to a team meeting or development session and identify actions or strategies from this review that you can implement to improve practice, particularly regarding domestic abuse and how to identify and deal with the early signs of it.

Multi-agency Info Sharing
An IRD would have been beneficial for this case. With evidence of good info sharing, it was clear there had been delays and discrepancies of information recorded by agencies which meant decisions were not always made with a full appreciation of the circumstances. Markers on call handling systems for all emergency services and guidance regarding information to be included on medical recording systems would have assisted. A means by agencies to quickly identify if a person is/was designated an 'Adult at Risk' was also highlighted as learning.

Impact of Covid
Undoubtedly the pandemic had a moderate impact on Ms A directly/personally. The provision of a day service stopped meaning that she was restricted to her house, occasionally taken out during her weekly 1:1 support visit

Capacity
At the time of her death, Ms A had not undergone any formal capacity assessments. Her dementia diagnosis would not normally trigger a formal capacity assessment. Concerns regarding her capacity did not come to light until latterly by which time her health had significantly deteriorated and the priority was her safeguarding and medical treatment. Given this, no capacity assessments had been discussed. This was exacerbated by a lack of personal contact with Ms A.

Professional Curiosity
Levels of understanding regarding domestic abuse and coercive control resulted in little professional curiosity regarding Ms A's relationship with her husband. Telephone contact followed non attendance by MS A and her husband at appointments/respite care but this is restrictive. Best practice would be to attend and ensure a person centred approach. Covid-19 undoubtedly impacted on this.